

Implementation of the Medicare Managed Care CAHPS: Strategies for Reducing Barriers to Access and Increasing Effective Use of Services by Vulnerable Medicare Populations

Executive Summary

This report presents the findings from the Medicare Managed Care Qualitative Subgroup Analysis, the second facet of the Centers for Medicare & Medicaid Services (CMS) effort to assess the experiences and needs of four subgroups of the Medicare managed care population: disabled enrollees under the age of 65; seniors (over 65) in “frail” health; African American enrollees; and Hispanic enrollees. Round 1 of the subgroup analysis involved a quantitative assessment of the Medicare Managed Care Consumer Assessment of Health Plans Study (MMC CAHPS) survey, the instrument that CMS uses to monitor the quality of care and relative performance of Medicare managed care plans. Survey results from this first round of the analysis indicated the following:

- ◆ Enrollees who are eligible for Medicare due to disability, rather than age, have lower ratings of HMO performance across all dimensions of performance than other HMO enrollees;
- ◆ Aged enrollees who are in self-reported fair/poor health and who have limited independence also have lower ratings than other enrollees on most dimensions of HMO performance;
- ◆ Ethnic minority beneficiaries are more satisfied with their health plans overall when compared to other M+C enrollees; however, they are less satisfied specifically with the process of care and their ability to access needed services.

The goal of the qualitative subgroup analysis is to determine the basis for the above findings. The study team conducted literature reviews, site visits to eleven Medicare managed care plans, two rounds of Technical Expert Panel discussions, and numerous focus groups with subgroup beneficiaries in an effort to answer the following questions:

- ◆ What are the specific characteristics of each of these subgroups that may impact enrollees’ satisfaction with their health services under a managed care arrangement?
- ◆ How do beneficiaries in these four subgroups experience their care and access to services under a Medicare managed care plan?
- ◆ What can be done to improve enrollees’ levels of satisfaction and the quality of care that they receive?

A careful review of the findings from all four of the study methods suggests that, regardless of the individual's age, race, or disability status, M+C beneficiaries viewed their plan experiences positively or negatively along three critical dimensions:

- ◆ Enrollee health status
- ◆ Enrollee financial status
- ◆ The enrollee's ability to negotiate the barriers inherent in the managed care system

Specifically, enrollees expected that when they had a health condition requiring medical treatment, the managed care plan would cover the cost of the necessary services. When those services were denied by the plan, individuals often required assistance either to negotiate the intricacies of a plan's bureaucracy (and get the decision overturned) or to locate an alternative, affordable source of treatment. It was this issue of assistance *qua* advocacy that emerged as most difficult for many of our focus group participants, but that also suggested the most possible solutions. Suggestions were made for solutions to come from the plans themselves, as well as from individuals outside of the managed care structure.

Plan-Based Solutions

Case Management and Disease Management

Given that the MMC CAHPS data evinced a direct correlation between plan satisfaction and enrollees' health status, one might anticipate that improvements in beneficiaries' health care would lead *indirectly* to an increase in plan satisfaction. Two programs instituted by several of the site visit plans would seem to lend themselves to enhanced consumer satisfaction. Case management, for example, aims to prevent downturns in an enrollee's health by ensuring that preventive and maintenance services are received in a regular and timely fashion. Similarly, disease management programs are oriented at stabilizing the enrollee's health by instituting strategies that can ameliorate the effects of chronic disease conditions. While both case management and disease management are utilized by M+C plans with an eye towards balancing quality care and financial sustainability, these programs should also maintain or improve enrollees' health and, by extension, their satisfaction with their plans.

Clarity in plan benefits

A second concern expressed by beneficiaries was that when they did have a need for services, it was not always clear from the plan materials the benefits for which they were eligible. In some cases, they said, the plan information was in dense, booklet form, and not easily understood by anyone without a law degree; more often, however, enrollees wanted information in a format that was clear, simple, and easy to understand. While beneficiaries who were not native speakers of English requested plan information in their native languages, the issue actually transcended traditional notions of "cultural competence." For example, individuals with visual impairments requested that plan information and updates be made available in auditory or Braille formats. And numerous focus group participants suggested that enrollees with cognitive challenges needed to receive benefits information via forms or processes that accommodated those impairments. The request was thus not just that plans disseminate benefits information in a

culturally appropriate way, but in ways that could be accessed and understood by enrollees with any number of characteristics and challenges.

In addition, focus group participants in almost every site expressed their belief that, contrary to Medicare policy, plans were changing their benefits structure mid-year. A more likely explanation, however, is that beneficiaries – uncertain as to who was actually sponsoring their health insurance – were confusing their Medicare plans (which had not changed) with their employer-sponsored plans (whose benefits structures can change throughout the year). Beneficiaries were less upset by the mid-year changes than by the fact that they often learned of the alterations after they called to schedule an appointment with a provider (no longer in the plan) or to receive a previously-covered treatment. This finding reinforces their previous request that any and all changes to plan benefits be conveyed to enrollees in an easily understood (see above) manner and via a format that can be readily referenced throughout the plan year.

Reasonable response time on phone

Consonant with the above point, beneficiaries reported that when they had a question about their benefits and called the toll-free number to get additional information, the processes through which they had to go to get their questions answered were difficult and involved. In some cases, they said, they had to wander through a maze of push-button options (“for information about X press 1”), sometimes only to get punted to an answering machine or kicked out of the phone queue altogether. Individuals with various cognitive impairments, we were told, had significant difficulties trying to negotiate the option maze, which required a level of patience and attention to detail and sequencing that many beneficiaries do not have.

While many enrollees said that they could deal with the telephone hurdles, they were loathe to do so when they failed to reach a “live” person in a reasonable amount of time. Long waiting periods “on hold,” or even abbreviated waiting times to leave an answering machine message were deemed inadequate by most of the participants, who wanted their questions answered in a more timely fashion. Stricter monitoring of help lines, or even more stringent requirements for responding to incoming calls, may help to alleviate some of these concerns.

Plan-Sponsored Peer Communication Events


The focus groups provided the research team with numerous opportunities to observe the benefits that naturally accrued to individuals who participated in these interactions. Although each group developed its own unique dynamics, in almost every instance certain group participants took on the role of peer supports for others. Sometimes it was a simple dynamic, whereby individuals shared their experiences and their respective approaches to solving a common problem. Just as often, though, empowered members of the group took up “the cause” of their less-empowered colleagues, sharing names of physicians who were particularly well-liked, offering ideas about where enrollees could go for possible financial assistance, and even suggesting where individuals might be able to receive affordable treatment when they needed services not covered by the HMO. Focus group participants widely noted the power in the group process, and suggested that plans support regular get-togethers by enrollees for sharing of ideas, experiences, and socialization.

Advocacy Outside the Plan

One of the most important lessons offered by the beneficiaries was that because of cognitive or other challenges, many of them required additional support or advocacy in order to receive the medical care that they needed. In one of the site visit plans, beneficiaries received a membership card that had a picture of their “Dedicated Customer Service Representative.” This Representative was promoted by the plan as the individual who “could answer any questions” and could assist the beneficiary with getting needed services. Given the competing interests of the beneficiaries and the plans – i.e., that both parties are looking to the other to absorb the cost of health services – it would seem important for the advocate to be someone *not* directly linked to the plan itself. One promising example was found at one site visit, where plan enrollees had access to an ombudsperson whose job was to report not to the plan, but to the county health department.

Conclusions

Overall, the findings from the focus groups and the other three study methods seem to suggest that Medicare managed care beneficiaries *as a group* can be viewed as a vulnerable population. Despite the fact that many were in relatively good health, they recognized that their advanced age carries with it the potential for a serious health crisis, which in turn could mean financial destitution. They thus viewed Medicare HMOs as offering the possibility of striking the delicate balance between good health care services and financial integrity – so long as the plans came through during the inevitable health crisis. CMS’ efforts to monitor the M+C plans and enrollees’ satisfaction must walk this same fine line, ensuring that reasonable health care service is delivered to beneficiaries in a cost-effective manner. The suggestions offered in this report may serve as a first step towards understanding the perspectives of the M+C enrollees, as well as recognizing possible directions that may lead to improvements in the way Medicare beneficiaries are served.

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